

# STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Form 9, Film 191 1-2-56 et  
**2971** **CERTIFICATE OF DEATH**

Reg. Dist. No. **02948**  
**202**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Chesertown</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u> c. LENGTH OF STAY IN 1b <u>40 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent + 24 Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u> d. STREET ADDRESS <u>Chesertown md</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Beile</u> First <u>Allen</u> Middle <u>Allen</u> Last		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>21</u> Year <u>1906</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9-12-87</u> <b>9. AGE</b> (In years) <u>21</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>		<b>13. FATHER'S NAME</b> <u>Charles Benson</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Cox</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>218-16-7630</u> <b>17. INFORMANT</b> <u>Hospital Records</u> Address		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260x</u> (b) <u>congestive Heart Failure</u> DUE TO (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Possible Tuberculosis</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <u>19</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <u>3/11</u> , 19 <u>56</u> , to <u>3/21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/21</u> , 19 <u>56</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown Maryland</u> DATE SIGNED <u>3/21/56</u>							
<b>ACTUAL SIGNATURE</b> <u>Thomas J. Solon</u> M.D. <b>PHYSICIAN'S NAME</b> (Type) <u>Thomas J. Solon</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3/24/1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Chester Cem.</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Chestertown, Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>St Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Mar 24-56</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Class S. Barnes</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. Pages 1 and 2 should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED  
MAR 27 1956  
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2972 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02949** **202**

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN lb <b>1 1/2 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent and Queen Anne Hospital</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>216 Calvert St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>MAKX</b> Last <b>Brown</b>			4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/17/1917</b>	9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months <b>39</b> Days <b>7</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic labor</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Queen Anne Co. Maryland</b>	
13. FATHER'S NAME <b>William Sparks</b>			14. MOTHER'S MAIDEN NAME <b>Bessie Roechester</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-28-1427</b>		17. INFORMANT <b>Charles Brown</b> Address <b>216 Calvert St Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>678X</b> IMMEDIATE CAUSE (a) <b>Probable particulate embolism (fluid amniotic)</b> DUE TO <b>Pregnancy and labor at full term</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 hours</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Arthur T. Keefe</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>March 8, 1956</b>	
EXAMINER'S NAME (Type) <b>Arthur T. Keefe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/10/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rich Neck Hall Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Queen Anne Co. Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>Mar. 10-1956</b>	24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>

MASSACHUSETTS DEPARTMENT OF HEALTH-CARNOUGH 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

MAR 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing it and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02950

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 291, Millington</u>		c. LENGTH OF STAY IN 1b <u>Millington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 291, Millington, Md.</u>		d. STREET ADDRESS <u>X</u>	
3. NAME OF DECEASED (Type or print) <u>Alonzo</u> First <u>Burriss</u> Middle <u>Burriss</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/23/1915</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vita Food Products</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Clarence Burriss</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Ross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-03-2800</u>	
17. INFORMANT <u>Sheriff Bartus Vickers, Chestertown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>instantaneous</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>automobile accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:30</u> Hour <u>  </u> o. m. <u>  </u> p. m. <u>3/24/5 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. 291</u>		20f. (City or town) (County) (State) <u>Millington Kent Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Robert W. Farr</u>		DATE SIGNED <u>March 24, 1956</u>	
EXAMINER'S NAME (Type) <u>Robert W. Farr, M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 28 55</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chesterville</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Millington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		24a. REC'D BY REGISTRAR DATE <u>3/27/53</u>	
ADDRESS <u>Millington Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Edward Fellows</u>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
SUBSTITUTIONAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 2 1950

RECEIVED

2979

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCUST GROVE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCUST GROVE</u> X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>AGNES</u> <u>GARY</u>				4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>17</u> <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 3, 1876</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>ALFRED T. McGUIRE</u>				14. MOTHER'S MAIDEN NAME <u>CORA WEBB</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HARRY R. GARY,</u> Address <u>LOCUST GROVE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis.</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days.</u> <u>2 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Mar 13, 1956</u> , to <u>Mar 17, 1956</u> , that I last saw the deceased alive on <u>Mar 16, 1956</u> , and that death occurred at <u>230 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Still Pond Md</u> DATE SIGNED <u>3/18/56</u>							
ACTUAL SIGNATURE <u>L. P. Atwell</u> M.D.				PHYSICIAN'S NAME (Type) <u>L. P. ATWELL</u> <u>STILL POND, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GALENA CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>GALENA, KENT Co., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward T. Bellows, Mellinville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3/21/56</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth J. Mueford</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1955

<p>1. Name of deceased</p>	
<p>2. Sex</p>	
<p>3. Date of birth</p>	
<p>4. Place of birth</p>	
<p>5. Date of death</p>	
<p>6. Place of death</p>	
<p>7. Cause of death</p>	
<p>8. Signature of physician</p>	
<p>9. Signature of registrar</p>	
<p>10. Signature of informant</p>	

BUREAU V.

MAR 23 1956

RECEIVED

2973

## CERTIFICATE OF DEATH

Reg. Dist. No. 2102

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown			
c. LENGTH OF STAY IN 1b 1 hr.				d. STREET ADDRESS 210 S. Front			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 72 Kent & Queen Anne Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CARROLL GIBBS SR.				4. DATE OF DEATH Month Day Year March 9 1956			
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1884	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler		10b. KIND OF BUSINESS OR INDUSTRY Private Home		11. BIRTHPLACE (State or foreign country) Kent County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Gibbs				14. MOTHER'S MAIDEN NAME Jane Saunders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Mary Gibbs, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary insufficiency - (Pulmonary edema) 1/2-3/4 hour DUE TO (b) Coronary arterio sclerosis - several years DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1954 to 3-9 1956 that I last saw the deceased alive on 3-9 1956, and that death occurred at 7:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert W. Farr				DATE SIGNED 3/14/56			
PHYSICIAN'S NAME (Type) ROBERT W. FARR				ADDRESS (Street, city or town, state) M.D. Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11, 1956		22c. NAME OF CEMETERY OR CREMATORY Sandy Bottom		22d. LOCATION (City, town, or county) (State) Near Fairlee, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.				24a. REC'D BY REGISTRAR DATE Mar. 13-56		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

NO. 3 1055

RECEIVED

2980

## CERTIFICATE OF DEATH

02952 201

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>KENT</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WORTON</b> c. LENGTH OF STAY IN 1b <b>LIFETIME</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD WORTON</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>MARIE</b> Last <b>HADDAWAY</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>15</b> Year <b>1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 21, 1897</b>
9. AGE (In years last birthday) <b>58</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>THOMAS L. MEEKS</b>		14. MOTHER'S MAIDEN NAME <b>LIDA COPPER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>THOS. A. HADDAWAY</b>		Address <b>WORTON R.D. MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Kidney.</b> <b>170X</b> DUE TO (b) <b>Uremic Poison.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Loss of 1 Kidney by operation 10 years ago.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 13, 1956</b> , to <b>Mar 15, 1956</b> , that I last saw the deceased alive on <b>Mar 15, 1956</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Still Pond Md</b> DATE SIGNED <b>3/16/56</b> ACTUAL SIGNATURE <b>L. P. Atwell</b> M.D. <b>STILL POND MD</b> PHYSICIAN'S NAME (Type) <b>L. P. ATWELL</b> M.D. <b>STILL POND MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-18-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CHESTER CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CHESTERTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor H. Kennedy</b>		ADDRESS <b>STILL POND, MD.</b>	
24a. REC'D BY REGISTRAR <b>3/17/56</b>		24b. REGISTRAR'S SIGNATURE <b>E. Keenard Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. This certificate has been signed by the attending physician and completed. It will be filed in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 1900



2974

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West town				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West town			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Nicholson Road - Broad Neck				d. STREET ADDRESS Broad Neck			
3. NAME OF DECEASED (Type or print) First Middle Last Wm. B. Nicholson				4. DATE OF DEATH Month Day Year March 1, 1955			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1884		9. AGE (In years last birthday) 71 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Phila. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Sutton				14. MOTHER'S MAIDEN NAME Anna Reigel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Wm. B. Nicholson, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Advanced myocardial disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atrial fibrillation DUE TO Arteriosclerotic cardiovascular disease (c)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 10 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-4-1955, to March 1, 1955, that I lost the deceased on 1-21-1955, and that death occurred at 6:30a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A.C. Dick M.D. Chestertown, Maryland 3-2-55 PHYSICIAN'S NAME (Type) A. C. Dick Chestertown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 3/55		22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cemetery near West town, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE Mar. 3-1955		24b. REGISTRAR'S SIGNATURE Clara L. Barnes.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. A. C. 1972

1972

2981

## CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STILL POND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STILL POND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SALLIE A. PRICE</b>		4. DATE OF DEATH Month Day Year <b>MARCH 25 1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 18, 1872</b>
9. AGE (In years last birthday) <b>83</b> yrs		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN HURLOCK</b>		14. MOTHER'S MAIDEN NAME <b>SARAH POORE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ALTA P. GEARY</b>		Address <b>STILL POND, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>virus fatigues</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>General Sepsis</b> DUE TO (c) <b>Heart (Thrombosis)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 18, 1956</b> , to <b>March 25, 1956</b> , that I last saw the deceased alive on <b>March 25, 1956</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. P. Atwell</b> M.D.		ADDRESS (Street, city or town, state) <b>Still Pond Road</b> DATE SIGNED <b>3/26/56</b>	
PHYSICIAN'S NAME (Type) <b>L. P. ATWELL</b> M.D.		<b>STILL POND, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3-28-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>STILL POND CEMTY</b>	22d. LOCATION (City, town, or county) (State) <b>STILL POND MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>		24a. REC'D BY REGISTRAR DATE <b>3/26/56</b>	
ADDRESS <b>STILL POND, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>E. Kennedy Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. Filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed. Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

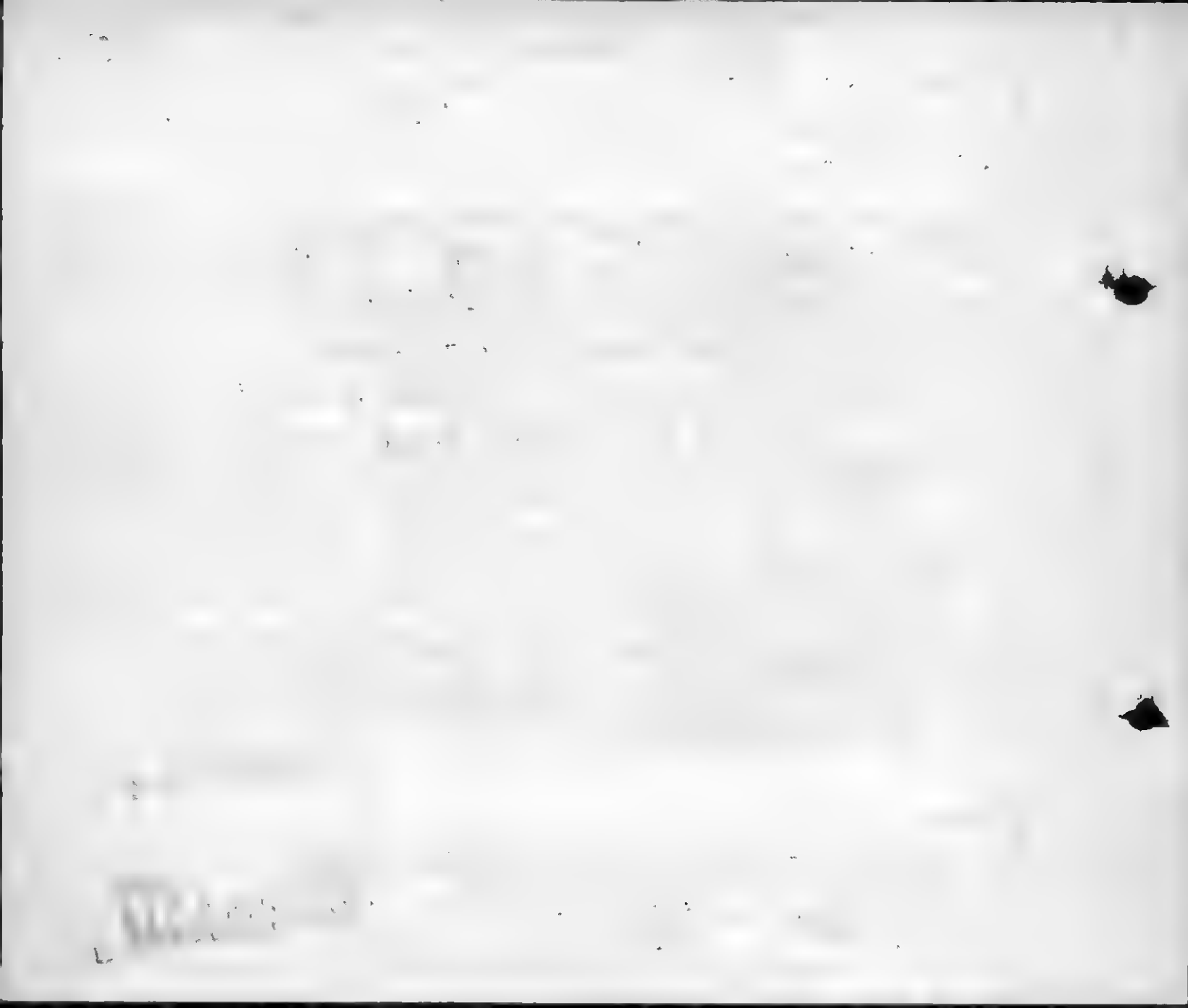
5 A 10000

# CERTIFICATE OF DEATH

Reg. Dist. No.

**MEDICAL CERTIFICATION**

VS A15 (4)  
ISM 9/SS



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2975

## CERTIFICATE OF DEATH

Reg. Dist. 02957

1. PLACE OF DEATH a. COUNTY <u>KENT</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARCLAY</u>			
c. LENGTH OF STAY IN 1b <u>11 days</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT + QUEEN ANNE'S</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DOUGLAS</u> Middle <u>ROCHESTER</u> Last <u>ROCHESTER</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 8, 1887</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ARTHUR ROCHESTER</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA HARRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTESTINAL OBSTRUCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>POST-OPERATIVE ADHESIONS</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR 1</u> , 19 <u>56</u> , to <u>MAR 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MAR 10</u> , 19 <u>56</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHESTERTOWN, Md.</u> DATE SIGNED <u>3-11-56</u> ACTUAL SIGNATURE <u>C. T. Keefer Jr.</u> M.D. <u>CHESTERTOWN, Md.</u> PHYSICIAN'S NAME (Type) <u>ARTHUR T. KEEFER JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Rochester Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ingleside Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Daishell</u>				24a. REC'D BY REGISTRAR <u>Barry J. Barnes</u>		24b. REGISTRAR'S SIGNATURE <u>Barry J. Barnes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

RECEIVED  
MAR 19 56  
U. S. AIR FORCE

2976

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent &amp; Queen Anne Hospital</u>		STREET ADDRESS (If rural, give location) <u>RFD Queen Anne County</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Merton Vandike Sweeney</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 5, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>8/25/1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill</u>	9. AGE last birthday (If under 1 year Months Days) (If under 24 hrs. Hours Min.) <u>41 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Norman Sweeney</u>		14. MOTHER'S MAIDEN NAME <u>Idella Simpson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY No. <u>212-11-2938</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>
(a) Immediate cause <u>3rd. Degree Burns</u> <u>10 hrs.</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg, etc.) INJURY <u>home</u>		(CITY OR TOWN) (COUNTY) (STATE) <u>Queen Anne Co. Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6:20 A.M.</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection X, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: notural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. J. Henry Fisher M.D.Dep. Med. Exam.Centreville, Md.3/5/56

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF 3/8/56NAME OF CEMETERY OR CREMATORY Arlington NationalLOCATION (City, town, or county) Arlington, Va.

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 16-1956Classa S. BarnesJ. Willis Wells - Chestertown, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. L.

8

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 2983 CERTIFICATE OF DEATH

02959

Reg. Dist. No. 203

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

1. PLACE OF DEATH COUNTY <u>Kent</u> <u>Rock Hall</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rock Hall</u> LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rock Hall</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Ella</u> (First) <u>Tail</u> (Middle) (Last) 4. DATE OF DEATH <u>3</u> (Month) <u>10</u> (Day) <u>1956</u> (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>unknown</u>
9. AGE last birthday <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John T. Kiehl</u>		14. MOTHER'S/MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Wm. G. Smyth</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 1446X IMMEDIATE CAUSE (A) <u>Hypertension</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		15. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>✓</u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>and</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>✓</u>	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on <u>March 7, 1956</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>E. Kester</u> M.D. <u>Rock Hall</u> ADDRESS (Street, city, town, state) <u>and</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
DATE THEREOF <u>3/12/56</u>		REGISTRAR'S SIGNATURE <u>S. S. [unclear]</u>	
NAME OF CEMETERY OR CREMATORY <u>S.T. Paul's</u>		LOCATION (City, town, or county) <u>Chester Town Md.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill</u>	



2977

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>			c. LENGTH OF STAY IN 1b <u>16 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>172 Kent &amp; Queen Anne Hosp.</u>			d. STREET ADDRESS <u>Chestertown R. D. 1</u>		
3. NAME OF DECEASED (Type or print) First <u>WILLIAM H.</u> Middle <u>WHITELEY</u> Last			4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1956</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1883</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Queen Anne Co. Md.</u>	
13. FATHER'S NAME <u>Wm H. Whiteley</u>			14. MOTHER'S MAIDEN NAME <u>Emily Legg</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Maude R. Whiteley, Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 years ?</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Chestertown, Md.</u>	(County)	(State)
21. I certify that I attended the deceased from <u>2-26</u> , 19 <u>56</u> , to <u>3-12</u> , 19 <u>56</u> that I last saw the deceased alive on <u>3-12</u> , 19 <u>56</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Maryland</u> DATE SIGNED <u>3-13-56</u>					
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D. <u>Chestertown, Maryland</u>					
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)	
<u>Burial</u>	<u>March 14, 1956</u>	<u>Chester Cemetery</u>	<u>Chestertown, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams, Chestertown, Md.</u>			24a. REC'D BY REGISTRAR <u>Mar. 14-56</u>	24b. REGISTRAR'S SIGNATURE <u>Charles L. Barnes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this Certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. 2

MAR 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02961

## CERTIFICATE OF DEATH

Reg. Dist. No.

203

2934

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Rock Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharp Street</u>		d. STREET ADDRESS <u>Rock Hall</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE LOUISE WILLIAMS</u>		4. DATE OF DEATH Month Day Year <u>March 25 1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1882</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Downey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Dowling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Ruth A. Chaires, Rock Hall, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1, 1952</u> to <u>March 25, 1956</u> that I last saw the deceased alive on <u>March 24, 1956</u> and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u> DATE SIGNED <u>3/26/56</u>	
PHYSICIAN'S NAME (Type) <u>Willard F. Smith</u>		<u>Rock Hall, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 28/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams, Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>3/28/56</u> 24b. REGISTRAR'S SIGNATURE <u>S. Shoop</u>	

# CERTIFICATE OF DEATH

BUREAU V. S.

APR 4 1956

RECEIVED